						PRINTE	D: 01/02/2025	
DEPARTMENT	OF HEALTH AND HUN	MAN SERVICES				FORM	1 APPROVED	
EENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 093				
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLET	TED	
		155801	B. WI	NG		12/10/20)24	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH				305 E N	ADDRESS, CITY, STATE, ZIP COD IORTH ST VILLE, IN 47601			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	

(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
E 0000				
Bldg				
	An Emergency Preparedness Survey was	E 0000	By submitting the enclosed	
	conducted by the Indiana Department of Health in		materials, we are not admitting the	
	accordance with 42 CFR 483.73.		truth or accuracy of any specific findings or allegations. We	
	Survey Date: 12/10/24		reserve the right to contest the	
	Facility Number: 000450		findings or allegations as part of any proceedings and submit these	
	Provider Number: 155801		responses pursuant to our	
	AIM Number: 100273890		regulatory obligations. The facility requests the plan of correction be	
	At this Emergency Preparedness survey,		considered our allegation of	
	Transitional Healthcare of Boonville-North was		compliance effective 1/6/2025 to	
	found in compliance with Emergency		the state findings of the Life Safety	
	Preparedness Requirements for Medicare and		Code Recertification and	
	Medicaid Participating Providers and Suppliers, 42		Emergency Preparedness Survey	
	CFR 483.73		conducted on December 10, 2024.	
	The facility has 56 certified beds. At the time of			
	the survey, the census was 53.			
	Quality Review completed on 12/12/24			
K 0000				
Bldg. 01				
	A Life Safety Code Recertification and State	K 0000	By submitting the enclosed	
	Licensure Survey was conducted by the Indiana		materials, we are not admitting the	
	Department of Health in accordance with 42 CFR		truth or accuracy of any specific	
	483.90(a).		findings or allegations. We	
			reserve the right to contest the	
	Survey Date: 12/10/24		findings or allegations as part of	
	Facility Number: 000450		any proceedings and submit these responses pursuant to our	
	Provider Number: 155801		regulatory obligations. The facility	
	AIM Number: 100273890		requests the plan of correction be	
			considered our allegation of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Mike Van Hoy Administrator 12/26/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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ì ′		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u> b. wing			COMPLETED 12/10/2024	
		155801					
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH			IORTH ST /ILLE, IN 47601		
			<u> </u>				Г
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	,	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	1	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
1110	Healthcare of Boonville-North was found not in			1110	the state findings of the Life S	afetv	Ditte
		equirements for Participation in			Code Recertification and	aloty	
	-	Medicare/Medicaid, 42 CFR Subpart 483.90(a),			Emergency Preparedness Sur	vev	
	Life Safety from Fi	re and the 2012 edition of the			conducted on December 10, 2	-	
	National Fire Protect	ction Association (NFPA) 101,					
	•	LSC), Chapter 19, Existing					
	Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping						
		has a capacity of 56 and had a					
	census of 53 at the t	time of this survey.					
	All areas where resi	idents have customary access					
		d all areas providing facility					
	services were sprink						
	Quality Review con	mpleted on 12/12/24					
K 0300	NFPA 101						
SS=F	Protection - Other						
Bldg. 01							
		view and interview, the facility	K 03	00	K - 300		01/06/2025
		preventative maintenance for			The corrective action taken for	•	
		smoke alarms in resident			those residents found to have		
		ed according to manufacturer's ons. NFPA 101 in 4.6.12.3			been affected by the deficient practice is that although no		
	-	afety features obvious to the			specific residents were identifi	ad	
	-	ed by the Code, shall be			during the survey, all residents		
		72, 29.10 Maintenance and			staff and visitors have the pote		
		equipment shall be maintained			to be affected by this deficient		
	_	lance with the manufacturer's			practice. The facility has now		
	published instructio	ons and per the requirements			updated the policy on battery		
	•	A 72, 14.2.1.1.1 Inspection,			operated smoke alarms, which	1	
	-	nance programs shall satisfy			includes the instructions to tes	t	
	the requirements of this Code and conform to the				the alarms at least monthly or		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>01</u>			COMPLE	ETED
		155801	B. WING 12/			12/10/2	2024
		<u> </u>	' 	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R			NORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH			/ILLE, IN 47601		
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		eturer's published instructions.			more frequently as outlined by	the !	
		ice could affect all residents.			smoke alarms specific		
					manufacturer guidelines. The		
	Findings include:				smoke alarms are now being		
					tested weekly in accordance v	vith	
	Based on record review on 12/10/24 between 10:00				their specific manufacturer		
	a.m. and 3:00 p.m.	with the Administrator and the			guidelines.		
	Maintenance Super	visor present, the "Room			The corrective action taken for	r the	
	Smoke Detector Ba	ttery Operated Monthly			other residents that have the		
		owed monthly testing of the			potential to be affected by the		
	battery operated sm				same deficient practice is that	all	
	manufacturer's published instructions on the back				residents, staff and visitors ha	ve	
		alarm stated the alarms require			the potential to be affected by	this	
		sed on interview at the time of			deficient practice. The facility	has	
		Maintenance Supervisor			now updated the policy on bat	-	
		e tested monthly, and agreed			operated smoke alarms, which		
		e tested weekly according to			includes the instructions to tes		
	manufacturer's publ	lished instructions.			the alarms at least monthly or		
					more frequently as outlined by	the	
	_	viewed with the Administrator,			smoke alarms specific		
		tor, Clinical Operation			manufacturer guidelines. The		
	_	Operation Manager during			smoke alarms are now being		
	the exit conference.				tested weekly in accordance v	vith	
	3 1 10(b)				their specific manufacturer		
	3.1-19(b)				guidelines.	nut	
					The measures that have been into place to ensure that the	ραι	
					deficient practice does not rec	urie	
					that a mandatory in-service ha		
					been provided for all maintena		
					staff on the revised smoke ala		
					policy to ensure their		
					understanding of the requirem	ent	
					to test the smoke alarms in		
					accordance with the manufact	urer	
					guidelines and per the regulat		
					requirements.		
					The corrective action taken to		
					monitor to ensure the deficien		
					practice will not recur is that a		

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PRINTED: 01/02/2025 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 155801 B. WING 12/10/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 305 E NORTH ST TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH BOONVILLE, IN 47601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Quality Assurance tool has been developed and implemented to monitor the testing of the smoke alarms to ensure they are being tested in accordance with the new revised smoke alarm policy. This tool will be completed by the Executive Director and/or their designee weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. K 0324 **NFPA 101** SS=F Cooking Facilities Bldg. 01 Based on record review and interview, the facility K - 324 K 0324 01/06/2025 failed to ensure there was documentation The corrective action taken for available to show 1 of 1 kitchen exhaust systems those residents found to have was inspected semiannually. NFPA 96, 2011 been affected by the deficient Edition, Standard for Ventilation Control and Fire practice is that although no Protection of Commercial Cooking Operations, specific residents were identified Section 11.4 states the entire exhaust system shall during the survey all residents, be inspected for grease buildup by a properly staff and visitors in the main dining trained, qualified, and certified person(s) area have the potential to be acceptable to the authority having jurisdiction affected by this deficient practice. and in accordance with Table 11.4. Table 11.4, The facility has now had the range

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Schedule for Inspection for Grease Buildup,

semiannually. NFPA 96, 11.6.1 states, upon

inspection, if the exhaust system is found to be

contaminated with deposits from grease laden

system shall be cleaned by a properly trained,

vapors, the contaminated portions of the exhaust

qualified, and certified person(s) acceptable to the

requires systems serving moderate volume

cooking operations shall be inspected

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the regulations.

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hood exhaust system inspection

of this inspection is on file in the

completed and the documentation

facility records. The maintenance

supervisor will ensure that these

semi annually in compliance with

The corrective action taken for the

inspections will be completed

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/10/2024	
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	305 E N	ADDRESS, CITY, STATE, ZIP COD NORTH ST VILLE, IN 47601	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	authority having jur removal devices, far appurtenances shall combustible contambecoming heavily coily sludge. After the it shall not be coated substance. When an used, a certificate she servicing company, performing the world cleaning shall be matched the interest and residents, staff, dining room. Findings include: Based on record revalum, and 3:00 p.m. Maintenance Supercurrent semiannual	isdiction. Hoods, grease as, ducts, and other be cleaned to remove ainants prior to surfaces contaminated with grease or the exhaust system is cleaned, d with powder or other a exhaust cleaning service is anowing the name of the the name of the person at, and the date of inspection or aintained on the premises. Ice could affect kitchen staff and visitors while in the main iew on 12/10/24 between 10:00 with the Administrator and visor present, there was no inspection report available to	TAG	other residents that have the potential to be affected by the same deficient practice is that residents, staff and visitors in main dining room have the potential to be affected by this deficient practice. The facility now had the range hood exhat system inspection completed the documentation of this inspection is on file in the faci records. The maintenance supervisor will ensure that the inspections will be completed semi-annually in compliance with the regulations. The measures that have been into place to ensure that the deficient practice does not record that a mandatory in-service has been conducted for all maintenance staff on the	f all the has lust and lity has with a put sur is
	most recent range hinspection report av 04/18/24. Based on review, the Mainten aware that the inspehood was almost twalready been in contare scheduled to per 12/18/24. This finding was revisionally Maintenance Direct	ailable to review was dated interview at the time of record ance Supervisor said he was ction for the kitchen range o months past due and has tact with the vendor and they form the inspection on viewed with the Administrator, or, Clinical Operation Operation Manager during		regulation related to the semi-annual range hood exha system inspection requirement. The staff has been re-educate their responsibility of ensuring these inspections are scheduled and completed in a timely may and that a copy of each inspecies maintained on file in the fact Upon completion of each inspection, the maintenance supervisor will then schedule next inspection for six months following the most recent inspection. The corrective action taken to monitor to ensure the deficient practice will not recur is that the	ats. ed on that ed nner ction ility. the

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JENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039			
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED 12/10/2024			
		155801	B. WING					
	PROVIDER OR SUPPLIER	L CARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP COD 305 E NORTH ST BOONVILLE, IN 47601					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI	COMPLETION			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE			
				maintenance supervisor is now required to submit each semi-annual range hood exhau system inspection report to the Executive Director for review to ensure timely completion of this task. This will be an on-going process.	ıst			
K 0345	NFPA 101							
SS=F Bldg. 01	Fire Alarm System Maintenance 1. Based on record facility failed to ma accordance with NF Sections 19.3.4.5.1 14.3.1 states that un	review and interview, the intain 1 of 1 fire alarm system in FPA 72, as required by LSC 101 and 9.6. NFPA 72, Section aless otherwise permitted by ctions shall be performed in	K 0345	K 345 1.) The corrective action taken those residents found to have been affected by the deficient practice is that although no specific residents were identifie				
	more often if requir jurisdiction. Table must be visually ins a. Control unit troul b. Remote annuncia c. Initiating devices	ters (e.g. duct detectors, manual eat detectors, smoke detectors,		during the survey, all residents, staff and visitors have the poter to be affected by this deficient practice. The facility has now have a visual inspection of the facility fire alarm system including the smoke detectors and heat detectors. There is documentation of this visual inspection on file at the facility. The facility will continue to ensure	ntial nad y's			
		ice could affect all occupants		that semi-annual visual inspections are conducted of the facility's fire alarm system including the smoke detectors a	ne			
	Based on record rev a.m. and 3:00 p.m. Maintenance Super documentation prov	view on 12/10/24 between 10:00 with the Administrator and visor present, there was vided regarding an annual fire		heat detectors. 2.) The corrective action taken those residents found to have been affected by the deficient practice is that all residents, stand visitors have the potential to the content of the con	<i>for</i> aff			
	i aiarm system insneo	CHOOLOGIEG TITEE / 1/2 A NV The		I and vicitors have the hotential t	m I			

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facility's fire alarm inspection vendor, furthermore,

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be affected by this deficient

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/10/2024		
NAME OF P	ROVIDER OR SUPPLIER	.		EET ADDRESS, CITY, STATE, ZIP COI E NORTH ST)	
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH	ВО	ONVILLE, IN 47601		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREX (EACH CORRECTIVE ACTION SHOTH CROSS-REFERENCED TO THE APPROVIDER OF T	CTION	(X5)
PREFIX TAG	*	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG		PROPRIATE	COMPLETION DATE
		y inspections available dated		practice. The fire alarm	system	
	02/20/24, 05/29/24,	, and 08/23/24 by the facility's		inspection vendor was co	ontacted	
	fire alarm inspectio	n vendor, however, the		by the facility. The fire a	larm	
	quarterly inspection	documents did not provide		system inspection vendo	r's report	
	information about a	semi-annual visual inspection		now contains the informa	ation on	
	of the facility's fire	alarm devices, such as smoke		what testing instrument v	was used	
	detectors and heat d	letectors. For each device		to test all smoke detecto	rs for	
	listed on each of the	e quarterly reports it said, "Not		sensitivity. A copy of this	s report is	
	Tested". The facility	ty's pull stations were tested		now on file at the facility.	All	
	during each quarterly inspection. Based on			future fire alarm system	inspection	
	interview at the time of record review, the			reports will contain all the	e required	
	Administrator agree	ed the quarterly inspections		information as outlined b	y the	
	did not provide info	ormation of a semi-annual		regulation.		
	visual inspection of the facility's fire alarm system			The corrective action tak	en for the	
	devices, such as sm	oke detectors and heat		other residents that have	the	
	detectors.			potential to be affected b	y the	
				same deficient practice is	s that all	
	This finding was re	viewed with the Administrator,		residents, staff and visito	ors have	
	Maintenance Direct	tor, Clinical Operation		the potential to be affect	ed by this	
	Manager, and MDS	Operation Manager during		deficient practice. The fa	acility has	
	the exit conference.			now had a visual inspect	ion of the	
				facility's fire alarm syster	n	
	3.1-19(b)			including the smoke dete	ectors and	
				heat detectors. There is		
		review and interview, the		documentation of this vis	sual	
	_	sure complete documentation		inspection on file at the f	acility.	
	was available for th	e sensitivity testing of all hard		The facility will continue	to ensure	
		ors, and to show what testing		that semi-annual visual		
		d to test all smoke detectors		inspections are conducte	ed of the	
	_	PA 72, National Fire Alarm		facility's fire alarm syster	n	
		, Section 14.4.5.3.1 states		including the smoke dete		
	-	shall be checked within 1 year		heat detectors. The fire		
		every alternate year thereafter.		system inspection vendo		
		quired calibration test, if		contacted by the facility.		
		icate that the detector has		alarm system inspection	vendor's	
		listed and marked sensitivity		report now contains the		
	range, the length of time between calibration tests			information on what testi	ng	
	_	o be extended to a maximum of		instrument was used to t	est all	
	5 years. If the frequency	uency is extended, records of		smoke detectors for sens	sitivity. A	
	detector caused nui	sance alarms and subsequent	1	copy of this report is now	on file at	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	COMPLETED	
		155801	B. WINC	<u></u>		12/10/	/2024	
		1	<u>.</u> [;	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	t.			IORTH ST			
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH			ILLE, IN 47601			
					,			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE	
		ns shall be maintained. In			the facility. All future fire alarm	n		
		re nuisance alarms show an			system inspection reports will	_4:		
	-	evious year, calibration tests To ensure that each smoke			contain all the required informa	ation		
	-	s listed and marked sensitivity			as outlined by the regulation.	nut.		
		sted using any of the methods:			The measures that have been into place to ensure that the	ραι		
	(1) Calibrated test n				_	ur is		
	* *	calibrated sensitivity test			deficient practice does not rec that a mandatory in-service ha			
	instrument.	canorated sensitivity test			been provided for the mainten			
		quipment arranged for the			supervisor on what information			
	purpose.	quipment arranged for the			must be included in each fire	•		
	(4) Smoke detector/fire alarm control unit				alarm system inspection repor	t		
	arrangement whereby the detector causes a signal				The maintenance supervisor h			
	-	where its sensitivity is outside			been advised of their responsi			
	its listed sensitivity				to ensure that each fire alarm	~		
	-	sensitivity method acceptable			system inspection report is			
	to the authority hav	-			complete in its entirety to inclu	de		
	-	have sensitivity outside the			all items as outlined by the			
		ensitivity range shall be			regulation.			
	cleaned and recalib	rated, or replaced.			The corrective action taken to			
	The detector sensiti	vity cannot be tested or			monitor to ensure the deficient	t		
	measured using any	spray device that administers			practice will not recur is that a			
	an unmeasured con	centration of aerosol into the			copy of each fire alarm system	า		
	detector. This defic	cient practice could affect all			inspection report will now be			
	residents, staff, and	visitors in the facility.			submitted to the Executive			
					Director for review to ensure the	nat		
	Findings include:				all components of the report a			
					complete and that all required			
		view on 12/10/24 between 10:00			documentation has been			
	_	with the Administrator and			completed on each report. Th	is		
	-	visor present, there was			will be an on-going process.			
		lable to show a smoke						
		test of all hard wired smoke						
	-	rmed on 11/22/24 by the						
		system inspection vendor,						
	however, the report did not include the name of							
	the manufacturer's calibrated sensitivity test							
	instrument. This wa	-						
	Administrator at the	e time of record review.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/10/2024		
	ROVIDER OR SUPPLIER	CARE OF BOONVILLE - NORTH	STREET ADDRESS, CITY, STATE, ZIP COD 305 E NORTH ST BOONVILLE, IN 47601				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K 0346	Maintenance Direct Manager, and MDS the exit conference. 3.1-19(b) NFPA 101	viewed with the Administrator, or, Clinical Operation Operation Manager during					
SS=F Bldg. 01	failed to provide a comprotection of all occupants to be followed in the has to be placed out more in a twenty for with LSC, Section Suffects all occupants. Findings include: Based on record revealment and 3:00 p.m. of Maintenance Supersprovide fire watch of incomplete. The platfollowing: a. A time frame for fire alarm system is b. Contacting the Incomplete Incide on the IDOH Gatew Based on an interview this was confirmed. This finding was revealed to be followed by the Incide on the IDOH Gatew Based on an interview this was confirmed.	riew and interview, the facility complete written policy for the supants indicating procedures are event the fire alarm system of service for four hours or aur hour period in accordance 0.6.1.6. This deficient practice is in the facility. Tiew on 12/10/24 between 10:00 with the Administrator and visor present, the facility did locumentation, however, it was an failed to include the starting the fire watch if the out of service. DOH with the web link for ent Reporting System located ray. ew at the time of record review, by the Administrator. viewed with the Administrator, or, Clinical Operation Operation Manager during	K 0346		K - 346 The corrective action taken for those residents found to have been affected by the deficient practice is that although no specific residents were identified uring the survey, all residents staff and visitors have the potential to be affected by this deficient practice. The facility has now amended their fire watch policinclude the time frame for start the fire watch if the fire alarm system is out of service, as we as the contact information for IDOH web link for contacting the incident reporting system location the IDH gateway. The corrective action taken for other residents that have the potential to be affected by the same deficient practice is that residents, staff and visitors had the potential to be affected by deficient practice. The facility now amended their fire watch policy to include the time fram starting the fire watch if the fire alarm system is out of service well as the contact information.	ied s, ential ey to ting ell the tion r the tall ve this has e for e , as	01/06/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED	
		155801	B. WI	NG		12/10/	/2024
	PROVIDER OR SUPPLIE	CARE OF BOONVILLE - NORTH		305 E N	ADDRESS, CITY, STATE, ZIP COD NORTH ST /ILLE, IN 47601		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
	3.1-19(b)				IDOH web link for contacting to incident reporting system location the IDH gateway. The measures that have been into place to ensure that the deficient practice does not red that a mandatory in-service has been provided for all staff mer on the revised fire watch policion with special instructions in the area of when to start the fire wand how to report the fire system outage to IDOH. The corrective action taken to monitor to ensure the deficient practice will not recur is that the changes to the facility's fire was policy will be reviewed at the facility's Quality Assurance meeting to determine if any additional changes are warrar and to ensure that the policy meets all the requirements of regulation.	ation a put cur is as mbers by evatch eem at he atch	
K 0353 SS=E Bldg. 01	Based on observatifailed to ensure 4 of front porch entrance corrosion were repat 5.2.1.1.1 sprinkl leakage; shall be from the front porch in the oup-right, pendent, 6.2.1.1.2 any sprint the following shall	- Maintenance and Testing on and interview, the facility of 4 sprinkler heads under 1 of 1 e/exit overhang covered with laced. NFPA 25, 2011 edition, ers shall not show signs of ee of corrosion, foreign d physical damage; and shall correct orientation (e.g., or sidewall). Furthermore, at kler that shows signs of any of be replaced: (1) Leakage (2) ical Damage (4) Loss of fluid in	K 03	353	K - 353 The corrective action taken fo those residents found to have been affected by the deficient practice is that although no specific residents were identificating the survey, all resident staff and visitors have the potent to be affected by this deficient practice. The four corroded sprinkler heads identified on the front porch overhang have no	ied s, ential t	01/06/2025

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 12/10/2024 155801 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 305 E NORTH ST TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH BOONVILLE, IN 47601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the glass bulb heat responsive element (5) been replaced and are free of any Loading (6) Painting unless painted by the corrosion. sprinkler manufacturer. This deficient practice The corrective action taken for the could affect at least 5 or more resident, as well as other residents that have the staff and visitors while using the front porch area. potential to be affected by the same deficient practice is that all Findings include: residents staff and visitors have the potential to be affected by this Based on observations on 12/10/24 between 3:00 deficient practice. A house wide p.m. and 4:30 p.m. during a tour of the facility with inspection of all sprinkler heads the Administrator and Maintenance Supervisor, has now been completed and all there were four sprinkler heads under the front are free of any dirt, debris or porch entrance/exit overhang covered with corrosion. corrosion. Based on interview at the time of The measures that have been put observation, the Administrator and Maintenance into place to ensure that the Supervisor agreed the four sprinkler heads under deficient practice does not recur is the front porch overhang were covered with that a mandatory in-service has corrosion. been provided for the maintenance and housekeeping department This finding was reviewed with the Administrator, related to their responsibility to Maintenance Director, Clinical Operation ensure that all sprinkler heads are Manager, and MDS Operation Manager during kept clean and free of debris or the exit conference. corrosion. The staff was reminded to immediately report any signs of 3.1-19(b) corrosion of a sprinkler head to the maintenance department so that arrangements can be made promptly for the replacement of the identified sprinkler head. In addition, the facility's fire system vendor is schedule to conduct quarterly inspections of all sprinkler heads and replace any sprinkler heads that are corroded to ensure their proper functioning. The corrective action taken to monitor to ensure the deficient practice will not recur is that the maintenance supervisor will keep

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facility records on all quarterly

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 12/10/2024	
	THCARE OF BOONVILLE - NORT	305 E N H BOON	ADDRESS, CITY, STATE, ZIP COD NORTH ST VILLE, IN 47601		
PREFIX (EACH DEFI	ARY STATEMENT OF DEFICIENCIE CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
			inspections of the sprinkler he conducted by the fire system vendor as well as records of a sprinkler head replacements of file at the facility for inspection	II on	
K 0354 NFPA 101 SS=F Sprinkler Syst Bldg. 01	em - Out of Service				
Based on recorfailed to provide containing proception of all automatic spring out-of-service of period in accordance of the period in accordan	d review and interview, the facility e a complete written policy redures to be followed for the l occupants in the event the kler system has to be placed for 10 hours or more in a 24-hour dance with LSC, Section 9.7.5. LSC prinkler impairment procedures FPA 25, 2011 Edition, the Standard for, Testing and Maintenance of the Protection Systems. NFPA 25, mine procedures that the ordinator shall follow. A.15.5.2 (4) watch should consist of trained continuously patrol the affected costs to fire extinguishers and the otly notify the fire department are set to consider. During the patrol of reson should not only be looking king sure that the other fire area of the building such as egress in systems are available and perly. This deficient practice occupants in the facility. dee: d review on 12/10/24 between 10:00 m. with the Administrator and apervisor present, the facility did tech documentation, however, it was	K 0354	K - 354 The corrective action taken for those residents found to have been affected by the deficient practice is that although no specific residents were identified uring the survey, all residents staff and visitors have the potential to be affected by this deficient practice. The facility has now amended their fire watch policinclude the time frame for starthe fire watch if the fire alarm system is out of service, as we as the contact information for IDOH web link for contacting tincident reporting system loca on the IDH gateway. The policy was also amended to include name and contact information the facility's insurance compains the facility's insurance compains the corrective action taken for other residents that have the potential to be affected by the same deficient practice is that residents, staff and visitors had the potential to be affected by deficient practice. The facility now amended their fire watch policy to include the time fram starting the fire watch if the fire	ed s, ential y to ting ell he tion cy the of ny. r the all ve this has e for	

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 12/10/2024 155801 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 305 E NORTH ST TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH BOONVILLE, IN 47601 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE incomplete. The plan failed to include the alarm system is out of service, as following: well as the contact information for a. A time frame for starting the fire watch if the IDOH web link for contacting the sprinkler system is out of service. incident reporting system location b. Contacting the IDOH with the web link for on the IDH gateway. The policy contacting the Incident Reporting System located was also amended to include the on the IDOH Gateway, as well as contact name and contact information of information for the facility's Insurance Company. the facility's insurance company. Based on an interview at the time of record review, The measures that have been put this was confirmed by the Administrator. into place to ensure that the deficient practice does not recur is This finding was reviewed with the Administrator, that a mandatory in-service has Maintenance Director, Clinical Operation been provided for all staff members Manager, and MDS Operation Manager during on the revised fire watch policy the exit conference. with special instructions in the area of when to start the fire 3.1-19(b) watch, how to report the fire system outage to IDOH as well as the contact information of the facility's insurance company. The corrective action taken to monitor to ensure the deficient practice will not recur is that the changes to the facility's fire watch policy will be reviewed at the facility's Quality Assurance meeting to determine if any additional changes are warranted and to ensure that the policy meets all the requirements of the regulation. K 0500 **NFPA 101** SS=F **Building Services - Other** Bldg. 01

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Based on observation and interview, the facility

failed to ensure 4 of 4 fuel-fired tankless water

heaters had inspection certificates to ensure the

water heaters were in safe operating condition.

NFPA 101, Section 19.1.1.3.1 requires all health

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K 0500

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K - 500

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The corrective action taken for

those residents found to have

been affected by the deficient

practice is that although no

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u>			COMPLETED	
		155801	B. W	ING		12/10/	/2024
				CTREET	ADDRESS CITY STATE ZID COD	<u> </u>	
NAME OF F	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
TDANCO	ENDENT HEALTH	OADE OF BOONWILLE MODELL			IORTH ST		
TRANSC	ENDENT HEALTH	CARE OF BOONVILLE - NORTH		BOOM	/ILLE, IN 47601		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERS BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	T-	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	facilities to be design	gned, constructed, maintained,			specific residents were identifi	ed	
	_	nimize the possibility of a fire			during the survey, all residents	S.	
	-	g the evacuation of occupants.			staff and visitors have the pote		
		ice could affect all residents,			to be affected by this deficient		
	staff and visitors in				practice. The facility has now		
		,			the four fuel-fired tankless wat		
	Findings include:				heaters identified during the su		
					inspected and the inspection	a. 10 y	
	Based on observation	ons on 12/10/24 between 3:00			certificates are in place in		
		during a tour of the facility with			accordance with the regulation	1	
		nd Maintenance Supervisor,			Annual inspections will continu		
		kless fuel-fired water heaters in			be conducted per the regulation		
					The corrective action taken for		
	the Mechanical Room that were provided with blue State/Homeland Security identification tags,				other residents that have the	uie	
		e no inspection stickers or			potential to be affected by the		
		e to review. Based on			same deficient practice is that	all	
		e of observation, the			residents, staff and visitors ha		
		irmed all four fuel-fired tankless			the potential to be affected by		
		not provided with inspection			deficient practice. The facility		
	stickers or certificat				now had the four fuel-fired tan		
	stickers of certificat	tes to review.			water heaters identified during		
	This finding was re	viewed with the Administrator,			survey inspected and the	uic	
		tor, Clinical Operation			inspection certificates are in pl	200	
		Operation Manager during			in accordance with the regulat		
	the exit conference.				Annual inspections will continu		
	the exit conference.				be conducted per the regulation		
	3.1-19(b)				The measures that have been		
	3.1-17(0)				into place to ensure that the	ραι	
					I	ur io	
					deficient practice does not rec		
					that a mandatory in-service hat been conducted for the	is	
						:	
					maintenance supervisor on the	31f	
					responsibility to ensure that		
					annual inspections are conduc	iea	
					per regulation on all fuel-fired		
					tankless water heaters and tha	at	
					the required certifications are		
					posted as required.		
					The corrective action taken to		
					monitor to ensure the deficient	t	

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EL TEROTOI	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155801			l í	CONSTRUCTION	(X3) DATE SURVEY
		A. BUILDING B. WING	<u>01</u>	COMPLETED 12/10/2024	
	PROVIDER OR SUPPLIER	L CARE OF BOONVILLE - NORTH	305 E	T ADDRESS, CITY, STATE, ZIP COD NORTH ST IVILLE, IN 47601	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEPTICIENCY)	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	practice will not recur is that the maintenance supervisor will not provide the Executive Director annually with the supportive documentation of the required inspections of all fuel-fired tankless water heaters for the review to ensure compliance.	ow r
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and R	elocation Plan			
	failed to provide a committee fire safety presidents to accurate systems, plus a syst required by NFPA 19.7.2.2. LSC 19.7 occupancy fire safe the following: (1) Use of alarms (2) Transmission of (3) Emergency photo (4) Response to alartic (5) Isolation of fire (6) Evacuation of ir (7) Evacuation of street (8) Preparation of fire evacuation (9) Extinguishment Section 19.2.3.4(4) corridor shall not be width where serving patient sleeping roor required width shall equipment provided equipment during a	nmediate area noke compartment loors and building for	K 0711	K - 711 The corrective action taken for those residents found to have been affected by the deficient practice is that although no specific residents were identificating the survey, all resident staff and visitors have the potential to be affected by this deficient practice. The facility has now revised their fire safety plan to include the following; identifying the staff member who is responsible for calling 911 in the event of a fire emergency, identifying where the smoke barriers were located in the far and evacuation in detail, the unthe K-class fire extinguisher in kitchen in relationship with the of the kitchen overhead exhaus system, and the staff responsing the activation of the battery powered smoke alarms. The corrective action taken for other residents that have the potential to be affected by the	ied s, ential i ng the cility use of n the e use usting e to r the

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training program for the facility. The wheeled

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same deficient practice is that all

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER	A. BUILDING <u>01</u>		COMPI	COMPLETED	
155801		B. WING 12/10/2024			/2024		
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					NORTH ST		
TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH					/ILLE, IN 47601		
TIVAINOC	·	CARE OF BOOMVILLE - NORTH		DOON	, , , , , , , , , , , , , , , , , , ,		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID PREFIX		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL				(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.ΤΕ	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
	equipment is limite				residents, staff and visitors have		
	i. Equipment in use			the potential to be affected by this			
	_	ncy equipment not in use		deficient practice. The facility has			
	iii. Patient lift and transport equipment			now revised their fire safety plan to			
		tice could affect all occupants		include the following; identifying		ng	
	in the event of an e	mergency.		the staff member who is			
	F' 1' ' 1 1				responsible for calling 911 in t	.he	
	Findings include:				event of a fire emergency,		
	D 1 .	CA C TA LE			identifying where the smoke	• •	
		of the facility's Emergency		barriers were located in the facility		-	
	Procedure-Fire plan on 12/10/24 between 10:00 a.m. and 3:00 p.m. with the Administrator and			and evacuation in detail, the use of			
	_			the K-class fire extinguisher in the			
	Maintenance Supervisor present, the plan did not			kitchen in relationship with the use			
	address the following:			of the kitchen overhead exhausting system, and the staff response to			
	a. Identifying the staff member who is responsible				the activation of the battery		
	for calling 911 in the event of a fire emergency. b. The plan did address evacuation of the smoke				powered smoke alarms.		
	compartment; however, the plan did not identify			The measures that have been put			
	where the smoke barriers were located in the				into place to ensure that the		
	facility and evacuation in detail.				deficient practice does not recur is		
	c. The use of the K-class fire extinguisher in the			that a mandatory in-service has			
	kitchen in relationship with the use of the kitchen				been provided for all staff on the		
	overhead extinguishing system.				revisions of the facility's fire sa		
	d. Staff response to the activation of battery				plan with a focus on the additi	-	
	powered smoke alarms.			to the plan. Each staff member			
	Based on interview at the time of record review,		was instructed on their				
	the Administrator and Maintenance Supervisor			responsibilities in following the fire			
	acknowledged the Emergency Procedure-Fire plan			safety plan.			
	did not include the previously mentioned items.			The corrective action taken to			
	1 -7			monitor to ensure the deficient			
	This finding was reviewed with the Administrator,			practice will not recur is that the			
	Maintenance Director, Clinical Operation		fire safety plan will be reviewed at				
	Manager, and MDS Operation Manager during			least annually at the facility's			
	the exit conference				Quality Assurance meeting to		
					ensure that the fire safety plar		
	3.1-19(b)				complete and accurately mee	ting	
					all regulatory requirements.	-	
K 0712	NFPA 101		1				1
SS=C	Fire Drills		1				1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155801		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/10/2024				
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH			305 E	STREET ADDRESS, CITY, STATE, ZIP COD 305 E NORTH ST BOONVILLE, IN 47601				
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE			
Bldg. 01	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 1 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drill reports on 12/10/24 between 10:00 a.m. and 3:00 p.m. with the Administrator and Maintenance Supervisor present, 4 of 4 third shift (night) fire drills were 10:15 p.m. and 11:31 p.m. Based on interview at the time of record review, the Administrator and Maintenance Supervisor acknowledged the times of the third shift fire drills were performed and agreed the times were not varied enough. This finding was reviewed with the Administrator, Maintenance Director, Clinical Operation Manager, and MDS Operation Manager during the exit conference. 3.1-19(b) 3.1-51(c)		K 0712	K - 712 The corrective action taken for those residents found to have been affected by the deficient practice is that although no specific residents were identified during the survey, all residents staff and visitors have the pote to be affected by this deficient practice. The facility has now conducted a fire drill on third shat a staggered time which was least two hours different from the past two fire drills. The corrective action taken for other residents that have the potential to be affected by the same deficient practice is that residents, staff and visitors have the potential to be affected by the same deficient practice. The facility has now conducted a fire drill on the shift at a staggered time which was at least two hours different from the past two fire drills. The measures that have been into place to ensure that the deficient practice does not recut that a mandatory in-service has been conducted for the maintenance supervisor on the responsibility to ensure that fire drill times are staggered to ensure that they do not occur around the same time frame on the same shift. The fire drills will be staggered so that they do not consistently occur around the	ed , ntial nift at he the this has ird t put ur is s			

same time as the previous time on

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i i		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155801	A. BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 12/10/2024	
NAME OF PROVIDER OR SUPPLIER TRANSCENDENT HEALTHCARE OF BOONVILLE - NORTH			STREET ADDRESS, CITY, STATE, ZIP COD 305 E NORTH ST BOONVILLE, IN 47601				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
					each shift. The corrective action taken to monitor to ensure the deficient practice will not recur is that all drill reports will now be submit to the Executive Director for reto ensure that the time frames the fire drill times are staggered This review will be on on-going process.	t Il fire ted eview of ed.	

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